		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041814

Facility Name: Heartland Health Care Center-Henry

Address: 1650 Indian Town Rd (Number) Henry (City) 61537 (Zip Code)

County: Marshall

Telephone Number: (309) 364-3905 **Fax #** (309) 364-2247

IDPA ID Number: 344402510013

Date of Initial License for Current Owners: 10/10/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President of Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	85	Skilled (SNF)	85	31,110	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	8	Sheltered Care (SC)	8	2,928	5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,001	4,176	7,094	13,271	8
9	SNF/PED					9
10	ICF	1,789	13,174	212	15,175	10
11	ICF/DD					11
12	SC		1,521		1,521	12
13	DD 16 OR LESS					13
14	TOTALS	3,790	18,871	7,306	29,967	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.04%

D. How many bed-hold days during this year were paid by Public Aid?
2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 6,292

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	186,764	12,505	7,128	206,397	1,469	207,866		207,866			1
2	Food Purchase		141,837		141,837		141,837	(9,205)	132,632			2
3	Housekeeping	60,651	13,378	306	74,335		74,335		74,335			3
4	Laundry	40,947	7,795	201	48,943		48,943		48,943			4
5	Heat and Other Utilities			90,792	90,792	3,389	94,181	(4,201)	89,980			5
6	Maintenance	34,568	11,361	43,092	89,021		89,021		89,021			6
7	Other (specify):* Med Waste			569	569		569		569			7
8	**TOTAL General Services**	322,930	186,876	142,088	651,894	4,858	656,752	(13,406)	643,346			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	1,263,203	72,426	26,272	1,361,901	25,053	1,386,954		1,386,954			10
10a	Therapy	250,009	5,336	15,023	270,368		270,368		270,368			10a
11	Activities	36,455	4,177	1,180	41,812		41,812		41,812			11
12	Social Services	73,146	853		73,999		73,999		73,999			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,622,813	82,792	46,675	1,752,280	25,053	1,777,333		1,777,333			16
	C. General Administration											
17	Administrative	80,759		196,724	277,483	(62,962)	214,521		214,521			17
18	Directors Fees											18
19	Professional Services			21,596	21,596	(18,313)	3,283	(3,283)				19
20	Dues, Fees, Subscriptions & Promotions			39,734	39,734		39,734	(29,087)	10,647			20
21	Clerical & General Office Expenses	81,740	36,793	103,254	221,787	18,313	240,100	(96,123)	143,977			21
22	Employee Benefits & Payroll Taxes			412,858	412,858	23,033	435,891		435,891			22
23	Inservice Training & Education			2,510	2,510		2,510		2,510			23
24	Travel and Seminar			8,723	8,723		8,723		8,723			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,123	94,123		94,123		94,123			26
27	Other (specify):* Personal Purch			435	435		435		435			27
28	**TOTAL General Administration**	162,499	36,793	879,957	1,079,249	(39,929)	1,039,320	(128,493)	910,827			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,108,242	306,461	1,068,720	3,483,423	(10,018)	3,473,405	(141,899)	3,331,506			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Health Care Center-Henry #0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			180,050	180,050	10,018	190,068		190,068			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,112	5,112		5,112	(340)	4,772			32
33	Real Estate Taxes			93,729	93,729		93,729	7,091	100,820			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,464	8,464		8,464		8,464			35
36	Other (specify):* **G/L Assets**			1,259	1,259		1,259	(1,259)				36
37	**TOTAL Ownership**			288,614	288,614	10,018	298,632	5,492	304,124			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		204,475	9,683	214,158		214,158		214,158			39
40	Barber and Beauty Shops			12,519	12,519		12,519		12,519			40
41	Coffee and Gift Shops	17,447			17,447		17,447		17,447			41
42	Provider Participation Fee			46,666	46,666		46,666		46,666			42
43	Other (specify):* **Therapy Drugs**		33,904		33,904		33,904		33,904			43
44	**TOTAL Special Cost Centers**	17,447	238,379	68,868	324,694		324,694		324,694			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,125,689	544,840	1,426,202	4,096,731		4,096,731	(136,407)	3,960,324			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,205)	2		4
5	Telephone, TV & Radio in Resident Rooms	(24)	21		5
6	Rented Facility Space	(1,350)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(340)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,793)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(435)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,283)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,461)	21		24
25	Fund Raising, Advertising and Promotional	(29,087)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	7,091	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,470)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (136,407)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (136,407)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heartland Health Care Center-Henry

ID# 0041814

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	G/L Assets	$ (1,259)	36	1
2	Cable TV	(4,201)	5	2
3	Customer Reimb	(10)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,470)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Health Care Center-Henry **#** 0041814 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,205)	0	0	0	0	0	0	0	0	0	0	(9,205)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,201)	0	0	0	0	0	0	0	0	0	0	(4,201)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,406)	0	0	0	0	0	0	0	0	0	0	(13,406)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,283)	0	0	0	0	0	0	0	0	0	0	(3,283)	19
20	Fees, Subscriptions & Promotions	(29,087)	0	0	0	0	0	0	0	0	0	0	(29,087)	20
21	Clerical & General Office Expenses	(96,123)	0	0	0	0	0	0	0	0	0	0	(96,123)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(128,493)	0	0	0	0	0	0	0	0	0	0	(128,493)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(141,899)	0	0	0	0	0	0	0	0	0	0	(141,899)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(340)	0	0	0	0	0	0	0	0	0	0	(340)	32
33	Real Estate Taxes	7,091	0	0	0	0	0	0	0	0	0	0	7,091	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,259)	0	0	0	0	0	0	0	0	0	0	(1,259)	36
37	**TOTAL Ownership**	5,492	0	0	0	0	0	0	0	0	0	0	5,492	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(136,407)	0	0	0	0	0	0	0	0	0	0	(136,407)	45

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 196,724	HCR ManorCare, Inc	100.00%	$ 196,724	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	14,127	Heartland Management Services	100.00%	14,127		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 210,851			$ 210,851	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	$	$	3,983,481	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	3,983,481	1,469	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		3,983,481	377	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		3,983,481	3,012	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	3,983,481	21,882	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	3,983,481	3,171	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	3,983,481	27,988	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	3,983,481	105,773	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		3,983,481	6,612	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		3,983,481	16,421	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.			3,983,481	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		3,983,481	10,018	12
13										13
14	32	Interest				10,002,527				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 196,723	25

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank, Trustee		X	Finance Capital Addition	N/A		$ 81,733	$ 81,733			$ 5,112	1
2												2
3												3
4								Interest Income			(340)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 81,733	$ 81,733			$ 4,772	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 81,733	$ 81,733			$ 4,772	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heartland Health Care Center-Henry **#** 0041814 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 86,638	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 93,729	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,091	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,729	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 100,820	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	90,371	8
	2000	94,744	9
	2001	95,885	10
	2002	90,737	11
	2003	93,729	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Health Care Center-Henry COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0041814

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-09-326-001	See Attached	$ 93,728.58	$ 93,728.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 93,728.58	$ 93,728.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,130 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 174,000	1
2					2
3	TOTALS			$ 174,000	3

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1988	1988	$ 1,748,953	$ 43,724		$ 43,724	$	$ 739,366	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					77,653		77,653		566,454	9
10	Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)			1988	(161,519)						10
11	Land/Bldg Improvement (See attached schedule)			1988	487,372						11
12	Door Monitor			1989	2,438						12
13	Land/Bldg. Improvement (See attached schedule)			1990	242						13
14	Land/Bldg. Improvement (See attached schedule)			1991	9,067						14
15	Land/Bldg. Improvement (See attached schedule)			1992	8,628						15
16	Land/Bldg. Improvement (See attached schedule)			1993	19,910						16
17	Move Const Cost From CIP			1993	46,289						17
18	Audit Adj (#1) - Constr Cost			1993	(46,289)						18
19	Land/Bldg. Improvement (See attached schedule)			1994	3,550						19
20	Land/Bldg. Improvement (See attached schedule)			1995	7,068						20
21	(24) DOORS			1996	1,136						21
22	ADDITIONAL COST WALLCOVERING			1996	19						22
23	CARPET			1996	863						23
24	HVAC UPGRADE			1996	2,946						24
25	SEWER LINE CONNECTION			1996	2,398						25
26	SANITARY SEWER			1996	13,155						26
27	SEALCOAT & STRIPE PARKING LOT			1996	3,114						27
28	WALLCOVERING			1997	9,801						28
29	WALLCOVERING			1997	9,019						29
30	PAINTING & WALLCOVERING			1997	13,132						30
31	CROWN MOLDING FOR RENOVATION			1997	198						31
32	CARPET & WALLCOVERING			1997	3,245						32
33	VINYL WALL COVERING FROM INVENTORY			1997	343						33
34	ADDL'T COST FOR HOT WATER			1997	4,822						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	THERMOSTATIC MIXING VALVE	1998	$ 15,929	$		$	$	$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,562,904	$ 121,377		$ 121,377	$	$ 1,305,820	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,562,904	$ 121,377		$ 121,377	$	$ 1,305,820	1
2	PAINTING	2000	3,000						2
3	PAINTING FOR RESIDENTS ROOMS	2000	906						3
4	DOOR HARDWARE	2000	730						4
5	PAINTING	2000	3,000						5
6	PAINTING	2000	(3,000)						6
7	DRYWALL	2000	7,280						7
8	SMOKE DAMPERS	2000	658						8
9	ADDL'T COST SMOKE DAMPERS	2000	73						9
10	TOTAL DOORS	2000	610						10
11	WALLCOVERING	2000	170						11
12	WALLCOVERING	2000	709						12
13	WALLCOVERING	2000	519						13
14	WALLCOVERING	2000	299						14
15	CEILING	2001	1,225						15
16	CUSTOM WORKSTATION	2001	2,067						16
17	PAINT & WALLCOVERING	2001	1,760						17
18	WALLCOVERING - LOUNGE RENOVATION	2001	557						18
19	WINDOWS	2001	855						19
20	HOT WATER HEATERS	2001	7,900						20
21	DRAPES	2001	2,980						21
22	CARPET	2001	29,586						22
23	ADDTL COSTS FOR CARPET	2001	2,260						23
24	CARPET	2001	500						24
25	WALLCOVERING	2001	516						25
26	WALLCOVERING	2001	90						26
27	CARPENTRY - LOUNGE RENOVATION	2001	6,002						27
28	DRAPES, SHADES, BLINDS - LOUNGE RENOVATION	2001	1,109						28
29	CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION	2001	10,360						29
30	PAINTING, WALLCOVERING - LOUNGE RENOVATION	2001	9,691						30
31	PLUMBING - LOUNGE RENOVATION	2001	4,425						31
32	CONCRETE	2001	2,248						32
33	CPQ SUC PK 3YR	2001	932						33
34	TOTAL (lines 1 thru 33)		$ 2,662,921	$ 121,377		$ 121,377	$	$ 1,305,820	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,662,921	$ 121,377		$ 121,377	$	$ 1,305,820	1
2	ROOFING	2002	12,870						2
3	INSTALL LIGHTING	2002	2,065						3
4	FLOORING,PAINTING,VWC	2002	16,778						4
5	ARTWORK	2002	1,390						5
6	AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						6
7	ROOF	2003	57,188						7
8	OVERHEAD & INTEREST	2003	224						8
9	AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						9
10	ADDITIONAL ROOF COSTS	2003	16,778						10
11	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						11
12	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						12
13	DOORS	2003	5,757						13
14	OUTDOOR SECURITY LIGHTING	2003	6,525						14
15	OUTDOOR SECURITY LIGHTING	2003	725						15
16	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						16
17	Resilient Flooring	2004	22,526						17
18	Automatic Door	2004	4,630						18
19	Electrical	2004	1,440						19
20	Wallcovering	2004	397						20
21	Vinyl Wall Covering	2004	72						21
22	Vinyl Wall Covering	2004	162						22
23	Vinyl Wall Covering	2004	62						23
24	Vinyl Wall Covering & Border	2004	3,260						24
25	Vinyl Wall Covering	2004	229						25
26	Credits on Wallcovering	2004	(18)						26
27	Cove Base	2004	400						27
28	Bathroom doors, locks, & Floor	2003	40,831						28
29	Smoke Dampers	2004	1,996						29
30	Smoke Dampers	2004	222						30
31	Flooring, VCT	2004	10,420						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,902,675	$ 121,377		$ 121,377	$	$ 1,305,820	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,059,428	$ 58,673	$ 58,673	$		$ 862,850	71
72	Current Year Purchases	126,681						72
73	Fully Depreciated Assets							73
74	H/O Allocation			10,018	10,018			74
75	TOTALS	$ 1,186,109	$ 58,673	$ 68,691	$ 10,018		$ 862,850	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,262,783	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,050	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,068	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,018	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,168,670	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 205,164	92
93			93
94			94
95		$ 205,164	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,464 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	5196	hrs	$ 115,033	276	$ 6,911	$ 1,936	5,472	$ 123,880	1
2	Licensed Speech and Language Development Therapist	10a	1024	hrs	22,672	32	810	80	1,056	23,562	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	5072	hrs	112,304	275	6,874	3,320	5,347	122,498	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				204,475		204,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): EKG, X-Ray,Lab	10, Col 3, 39					10,111			10,111	13
14	TOTAL				$ 250,009	583	$ 24,706	$ 209,811	11,875	$ 484,526	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland Health Care Center-Henry **#** 0041814 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,105	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (113,236))	421,979		3
4	Supply Inventory (priced at)	31,607		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,537		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 470,228	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	2,902,674		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,186,109		16
17	Accumulated Depreciation (book methods)	(2,168,670)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	205,164		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,299,277	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,769,505	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,172	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,405		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,729		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	32,924		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 336,230	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,733		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 81,733	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 417,963	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,351,542	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,769,505	$	48

***(See instructions.)**

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,114,064	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,114,064	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,272,804	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,272,804	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(1,035,326)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,035,326)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,351,542	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,475,940	1
2	Discounts and Allowances for all Levels	(175,432)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,300,508	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	806,461	6
7	Oxygen	19,011	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 825,472	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,575	12
13	Barber and Beauty Care	17,750	13
14	Non-Patient Meals	2,885	14
15	Telephone, Television and Radio	3,907	15
16	Rental of Facility Space	1,350	16
17	Sale of Drugs	190,522	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,326	19
20	Radiology and X-Ray	5,317	20
21	Other Medical Services	6,583	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 243,215	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	340	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 340	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,369,535	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	651,894	31
32	Health Care	1,752,280	32
33	General Administration	1,079,249	33
	B. Capital Expense		
34	Ownership	288,614	34
	C. Ancillary Expense		
35	Special Cost Centers	324,694	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,096,731	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,272,804	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,272,804	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,886	2,060	$ 55,994	$ 27.18	1
2	Assistant Director of Nursing	2,290	2,501	44,622	17.84	2
3	Registered Nurses	19,299	21,082	381,784	18.11	3
4	Licensed Practical Nurses	9,972	10,893	170,483	15.65	4
5	Nurse Aides & Orderlies	57,040	62,308	587,512	9.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	10,317	11,197	247,943	22.14	7
8	Rehab/Therapy Aides	48	52	2,066	39.73	8
9	Activity Director					9
10	Activity Assistants	3,806	4,168	36,455	8.75	10
11	Social Service Workers	4,261	4,666	73,146	15.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,312	22,244	186,764	8.40	15
16	Dishwashers					16
17	Maintenance Workers	1,743	1,908	34,568	18.12	17
18	Housekeepers	7,595	8,318	60,651	7.29	18
19	Laundry	5,156	5,644	40,947	7.25	19
20	Administrator	2,482	2,482	80,480	32.43	20
21	Assistant Administrator					21
22	Other Administrative	16	16	279	17.44	22
23	Office Manager					23
24	Clerical	7,418	8,902	99,187	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,530	1,675	22,808	13.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,171	170,116	$ 2,125,689 *	$ 12.50	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,200	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 4,200		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Legner	Administrator	0	$ 80,480
James Fox	AIT	0	279
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,759

B. Administrative - Other

Description	Amount
Home Office	$ 196,724
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 196,724

C. Professional Services

Vendor/Payee	Type	Amount
Kehr, Cassidy & Mueller	Legal Fees	368
McGuirewoods, LLP	Legal Fees	1,099
Michael T Mahoney	Legal Fees	100
Van Ostrand & Elvidge	Legal Fees	1,716
Misc Consulting	Spec Consult	18,313
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 21,596

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,679
Unemployment Compensation Insurance	32,719
FICA Taxes	149,610
Employee Health Insurance	195,404
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	6,683
Payroll Overhead Allocated	1
401K	16,667
Employee Uniforms	4,095
Home Office Allocation	23,033
TOTAL (agree to Schedule V, line 22, col.8)	$ 435,891

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,965
Advertising: Employee Recruitment	384
Health Care Worker Background Check (Indicate # of checks performed 79)	1,583
Dues & Subscriptions	812
Association Dues	4,299
Advertising	30,691
Less: Non-Allowable Association Dues	(1,366)
Less: Public Relations Expense	( )
Non-allowable advertising	(27,721)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,647

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,723
Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,723

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heartland Health Care Center-Henry # 0041814 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 4,299**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes ($1,366)**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,794** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **46,666**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(2,885)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.